TEXAS DEPARTMENT OF INSURANCE
Division of Workers' Compensation - Medical Fee Dispute Resolution (MS-48)
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MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name
TEXAS HEALTH FORT WORTH

Respondent Name
CITY OF FORT WORTH

MFDR Tracking Number
M4-18-0345-01

Carrier's Austin Representative
Box Number 04

MFDR Date Received
October 10, 2017

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "Claim denied due to timely filing. Patient's WC claim was sent for review on 01/08/2017, in which time was submitted to York Risk Services"

Amount in Dispute: $1,733.49

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "York has no record of receiving the bill neither in the claims system nor in the bill review system. There isn't any proof of receipt by York or an electronic transaction for E-billing. . . The original receipt of the date of service . . . by York as an E-Bill on was on 6/12/2017. The bill was processed and denied for timely filing on review . . . "

Response Submitted by: CareWorks Managed Care Services

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Dispute Amount	Amount Due
December 2, 2016 to December 30, 2016	Outpatient Hospital Occupational Therapy Services	$1,733.49	$0.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and applicable rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §133.20 sets out medical bill submission procedures for health care providers.
3. Texas Labor Code §408.027 sets out provisions related to payment of health care providers.
4. Texas Labor Code §408.0272 provides for certain exceptions to untimely submission of a medical claim.

5. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
   - 29 – THE TIME LIMIT FOR FILING HAS EXPIRED
   - 193 – ORIGINAL PAYMENT DECISION IS BEING MAINTAINED. UPON REVIEW IT WAS DETERMINED THAT THIS CLAIM WAS PROCESSED PROPERLY.
   - W3 – ADDITIONAL PAYMENT MADE ON APPEAL/RECONSIDERATION.

Issues

1. What is the timely filing deadline applicable to the medical bills for the services in dispute?
2. Did the requestor forfeit the right to reimbursement for the services in dispute?

Findings

1. The insurance carrier denied disputed services with adjustment code 29 – "THE TIME LIMIT FOR FILING HAS EXPIRED."

   28 Texas Administrative Code §133.20(b) requires that, except as provided in Texas Labor Code §408.0272, "a health care provider shall not submit a medical bill later than the 95th day after the date the services are provided."

   Texas Labor Code §408.0272(b) provides that, notwithstanding Section 408.027, a health care provider who fails to timely submit a claim for payment to the insurance carrier under Section 408.027(a) does not forfeit the provider's right to reimbursement for that claim for payment solely for failure to submit a timely claim if:

   (1) the provider submits proof satisfactory to the commissioner that the provider, within the period prescribed by Section 408.027(a), erroneously filed for reimbursement with:
   (A) an insurer that issues a policy of group accident and health insurance . . .
   (B) a health maintenance organization that issues an evidence of coverage . . .
   (C) a workers' compensation insurance carrier other than the insurance carrier liable . . .
   (2) the commissioner determines that the failure resulted from a catastrophic event . . .

   No documentation was presented to support that any of the exceptions described in Texas Labor Code §408.0272 apply to the disputed services. For that reason, the health care provider was required to submit the medical bill not later than 95 days following the date the services were provided.

2. Texas Labor Code §408.027(a) states that "Failure by the health care provider to timely submit a claim for payment constitutes a forfeiture of the provider's right to reimbursement for that claim for payment."

   Review of the submitted information finds no documentation to support that a medical bill was submitted within 95 days from the date(s) of service. The explanations of benefits show the earliest receipt date by the carrier was June 13, 2017. This date is later than the 95th day following the dates the services were provided. No evidence was presented to support an earlier receipt date by the insurance carrier. Accordingly the division finds the medical bills were not timely submitted to the insurance carrier. Consequently, the requestor has forfeited the right to reimbursement pursuant to Texas Labor Code §408.027(a).

Conclusion

For the reasons stated above, the division finds that the requestor has not established that additional reimbursement is due. As a result, the amount ordered is $0.00.

ORDER

Based on the submitted information, pursuant to Texas Labor Code Section 413.031, the division hereby determines the requestor is entitled to $0.00 additional reimbursement for the services in dispute.

Authorized Signature

	Grayson Richardson	October 31, 2017
Signature	Medical Fee Dispute Resolution Officer	Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute has a right to seek review of this decision in accordance with Rule §133.307, effective May 31, 2012, 37 *Texas Register* 3833, **applicable to disputes filed on or after June 1, 2012**.

A party seeking review must submit a Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision (form DWC045M) in accordance with the instructions on the form. The request must be received by the division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MFDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed. Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision* together with any other required information specified in 28 Texas Administrative Code §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.